STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVE RM 101 HONOLULU HAWAII 96816

SEBD REFERRAL FORM

SUPPORT FOR EMOTIONAL and BEHAVIORAL DEVELOPMENT (SEBD)

INSTRUCTION: Complete Part 1 and fax it to 733-8375, with a cover page, or to the nearest CAMHD Family Guidance Center. For questions, call (808) 733-9815.

PART 1. (TO BE COMPLETED BY THE REFERRAL SOURCE) Date:

CLIENT INFORMATION			
Client Name: Last First MI			Gender:
DOB:	SSN: - -	School attending:	
QUEST/Medicaid FFS ID:	Med-QUEST Eligibility Date:	Health Plan Name:	
Parent/Legal Guardian:		Phone No.:	
Mailing Address:			
Youth's address (if different from Parent/Guardian):		How long	

I hereby consent to the evaluation of my child for the purpose of determining SEBD eligibility and agree that CAMHD may obtain information about my child with the understanding that it cannot be disclosed to others without my further approval, unless permitted by Federal or State law. I also understand that this consent expires in one year.

Parent/Legal Guardian Signature: _____ Date: / /

REFERRAL SOURCE INFORMATION	
Referral Submission Date:	Referral Type: ☐ Initial ☐ Reconsideration
Referring Agency/Organization & Unit:	
Referring Person's Name/Phone/Fax:	

I hereby certify that the information I have provided is accurate to best of my knowledge and I recommend the above client for SEBD status consideration.

Referring Person's Signature: _____ Date: / /

If DHS has custody of youth, is it permanent custody ☐ Yes ☐ No

DSM-IV DX CODE	Primary	Secondary
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		
Diagnosis Date:	Diagnosed By:	

CAFAS (CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE)		**SUPPORTING DOCUMENTS** (List and attach assessments and plans to support diagnoses. If insufficient space, use separate sheet.)
Dimensions	Scores	Assessments
School/Work Role Performance	_____	
Home Role Performance	_____	
Community Role Performance	_____	
Behavior Toward Others	_____	Treatment/ Service Plans
Moods/Emotions	_____	
Self-Harmful Behavior	_____	
Substance Abuse	_____	Others
Thinking	_____	
8-SCALE TOTAL SCORE	_____	
Date CAFAS Administered:		

Client Name: _____

PSYCHOSOCIAL INTERVENTION STRATEGIES UTILIZED
(Check all that apply. If insufficient space or for other approaches, continue on separate sheet.)

Individual Therapy	Group Therapy	Family Therapy
☐ Individual Therapy	☐ Group Therapy	☐ Family Therapy
☐ Individual Interpersonal Therapy	☐ Group Psychoeducational Therapy	☐ Parent Psychoeducational Therapy
☐ Biofeedback Therapy		
☐ Cognitive Behavioral Therapy		
☐ Exposure Therapy		

HISTORY OF HOSPITALIZATION (Start with current hospitalization. If insufficient space, continue on separate sheet.)

Facility Name	Location	Admit Date	Discharge Date	Diagnoses

HISTORY OF MEDICATION TRIALS (Start with current medication. If insufficient space, continue on separate sheet.)

Medication Name	Strength	Freq	Start Date	End Date	Managing Physician	If Discontinued, Specify Reason

HISTORY OF OUTPATIENT TREATMENT (Start with current. If insufficient space, continue on separate sheet.)

Therapist/ Provider	Diagnoses	Start Date	End Date

PART 2. (TO BE COMPLETED BY THE FAMILY GUIDANCE CENTER)

FGC/Office:	CR#:
Current Registration Date:	
CAMHD BHP enrollment: ☐ yes ☐ no	

I hereby certify that I have reviewed this referral and reviewed the recommendation for the above client's SEBD status and recommend SEBD ☐ *Yes* ☐ *Provisional* ☐ *No.*

Clinical Director Signature: _____ Date: / /

PART 3. (TO BE COMPLETED BY THE SEBD REVIEW PANEL)

Determination Date:	Next Review Date:
SEBD Determination: ☐ Yes ☐ Provisional ☐ No	SEBD Begin Date:
Comments: ☐ Criteria Met ☐ Criteria Not Met ☐ Other (see below)	

Medical Director Signature: _____